Learning from Standardised ReviewsWhen Babies Die – 2020 Annual Report

Key Messages - October 2021



Since the launch of the national Perinatal Mortality Tool (PMRT) in early 2018 over 14,000 reviews have been started. This third annual report presents the findings for reviews completed from March 2020 to February 2021 coinciding with the first year of the SARS-CoV-2 global pandemic. Here are the key messages from the 3,981 reviews completed during this period.

Multi-disciplinary group review is essential



Parent engagement improves the quality of reviews

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90%	Parents told about the review
40%	No concerns or questions about care raised
16%	Communication was poor
54%	Concerns/questions about management plans
16%	Concerns/questions about technical aspects of care e.g. scans

Issue with care and areas for improvement identified at review



19 out of 20 reviews identified areas for improvement



5 out of 20 issues identified may have made a difference to the outcome

Comments, question and concerns raised by parents

Why was there not a discussion with us about delivery options when meconium was present?

Our concerns were not listened to by the midwives. Why were we discharged home when [baby's name] was blue around the lips?

The care I received during my pregnancy was second to none. I had frequent episodes of bleeding – why was I not kept in?

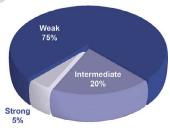
Why did no-one act when bleeding occurred at the ARM²?

I was not monitored and nothing was done.

My concerns about my baby's

movements were not taken seriously.

Action plans need to be strong¹



- Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardised and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing actions'
- 2. Artificial rupture of membranes
- 3. Electronic patient record

Examples of the strength¹ of actions planned

Weak Distribute communication to maternity staff regarding the

communication to maternity staff regarding the necessity for intrapartum antibiotics in preterm labour and the importance of this.

A reminder for individual action without any controls

Intermediate

Major review which led to a new staffing model and a newly appointed Lead for Triage and Induction.

A new system in place but still requires individuals to act without any controls

Strong

Process for assessing need for aspirin developed and implemented via EPR³

A system level electronic design to eliminate human error